Washington State Child Death Review Program Progress Report

A report summarizing the implementation of the Child Death Review Program 1998-2000

May 2001

Washington State Department of Health
Community and Family Health

Washington State Department of Social & Health Services

In memory of our colleague and friend, Carolyn Andersch, MA, Child Fatalities Program Manager with the Department of Social and Health Services Children's Administration. Carolyn had a vision of DSHS and DOH joining their child fatality review efforts to reduce deaths of Washington children. It is now a reality. Her unfailing guidance and support influenced every aspect of the Child Death Review program. We will truly miss her.

Carolyn Andersch died unexpectedly March 15, 2001.

The Washington State Child Death Review Committee

Dear Friends of Washington's Children:

Behind the pages of this Child Death Review Program Report are the faces of many unsung heroes throughout the state of Washington. Supported by funds from the legislature since 1998, thirty community-based, multi-disciplinary teams have diligently reviewed circumstances surrounding every unexpected death in their jurisdiction. What these teams all have in common is the vision that child death review can lead to improvements in systems that safeguard the lives of children. This is very important work..

The Departments of Health and Social and Health Services are committed to working with community-based partners in making the system improvements, in elucidating policy considerations, and in forging prevention strategies to keep this vision alive. The level of interagency and interpersonal commitment at the state and local level has been exemplary.

On behalf of Washington State children, we would like to thank and commend you for this work.

Sincerely,

Maxine Hayes
State Health Officer
Department of Health

Dennis Braddock
Secretary
Department of Social & Health Services

Washington State Child Death Review Program Progress Report 1998-2000

May 2001

Report prepared by

Melissa Allen, MSW
Department of Health Child Death Review Program Coordinator

Diane Pilkey, MPH, RN
Department of Health Child Death Review Data and Assessment Coordinator

For an electronic version of this document, please contact:
Washington State Department of Health
Maternal and Child Health Office
PO Box 47880
Olympia, WA 98504-7880
(360) 236-3536
melissa.allen@doh.wa.gov

Washington State Department of Health

Washington State Department of Social & Health Services

Mission

Washington's Child Death Review program reviews deaths of children who have unexpectedly lost their lives. Our responsibility is to determine any preventable circumstances in these deaths and consider strategies to improve overall health and safety for all children.

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Acknowledgments

We wish to give special acknowledgement to the dedication and support of the volunteers from throughout Washington who serve on the thirty child death review teams. Over 400 people share their valuable time and expertise to make the process a success and to help prevent needless child fatalities. Year 2000 membership rosters from every team are included in Appendix 2 of this report.

We would also like to acknowledge those individuals and organizations that helped make the state and local child death review system possible. These include:

The thirty-four local health jurisdictions in Washington State
Washington State Child Death Review Committee
Washington State Department of Social and Health Services
- Children's Administration - Division of Program and Policy
- Management Services Administration - Research and Data Analysis

Washington State Department of Health
- Vicki Sussman Gaelen – Child Death Review Data and Assessment Coordinator (10/99 – 9/00)
- Office of Maternal and Child Health
- Center for Health Statistics
- Injury Prevention & Safety Program
- Emergency Medical Services and Trauma Prevention

Office of Superintendent of Public Instruction
- School Nurse Corps

State of Washington Forensic Investigations Council
SIDS Foundation of Washington

Washington State Child Death Review Committee - Year 2000

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Rita Schmidt	Director, Maternal Child Health, DOH
Jacob Romo	Director, Program & Policy Division, DSHS Children's Administration

Members

Laurie Cawthon	DSHS Research and Data Analysis Represents DSHS Research & Data Analysis
Michael Curtis	Office of the Administrator for the Courts Represents Judicial Services & Education
Kikora Dorsey	Washington Council for Prevention of Child Abuse and Neglect Represents Child Abuse Prevention
David Estroff	Madigan Army Medical Center Represents Amer Academy of Pediatrics & Madigan Army Medical Center
Barbara Feyh	Community & Family Services, Spokane Regional Health District Represents WSALPHO Nursing Directors
Willa Fisher	Bremerton-Kitsap County Health District Represents Public Health Officers, WSALPHO
Steve Gobin	Tulalip Tribe Represents American Indian Health Commission
Ray Hansen	Thurston County Sheriff's Office Represents WA Assoc. of Sheriffs & Police Chiefs
Richard Harruff	King County Medical Examiner's Office Represents WA SIDS Foundation
Maxine Hayes	Washington State Health Officer, Represents DOH
Margaret Hobart	Washington State Coalition Against Domestic Violence Represents Fatal Domestic/Family Violence
Charles Howard	DSHS Health and Rehab Services, Division of Dev. Disabilities Represent DSHS Developmental Disabilities
Teresa Jennings	Department of Health Center for Health Statistics Represents DOH Vital Statistics
Donald Johnson	Department of Pediatrics, Bremerton Naval Hospital Represents Military Child Fatality Review

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Washington State Child Death Review Committee - Year 2000

Fred Johnson	Wahkiakum County Prosecutor / Coroner Represents Forensic Investigations Council
Karen Jones	Deputy State Fire Marshal Represents WSP Fire Investigation
Peter Keyser	Columbia Pediatrics Represents WA Chapter American Academy of Pediatrics
Emmanuel Lacsina	Forensic Pathology Represents Forensic Investigations Council
Judith Maire	Office of the Superintendent of Public Instruction Represents School Health
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Jack McClellan	DSHS Mental Health Div, Child Study and Treatment Center Represents DSHS Mental Health
Dick Nuse	Washington State Traffic Safety Commission Represents State Traffic Safety
Martha Reed	Mason County Coroner Represents WA Assoc. of Coroners & Medical Examiners
Nancy Reid	DOH Child and Adolescent Health Alternate For Rita Schmidt (Co-Chair)
Debbie Ruggles	DOH Injury Prevention Program Represents DOH Injury Prevention Programs
Madelyn Schwartz	WA State Youth Suicide Prevention Committee Represents WA State Suicide Prevention Coalition
Vickie Wallen	Office of the Family and Children's Ombudsman Represents Family and Children's Ombudsman
Margaret West	Chief Div of Health Resources Development Represents Federal Perspective on Child Death Review
Sharon Young	DSHS Children's Administration, Div of Program and Policy Alternate for Jacob Romo (Co-Chair)

Executive Summary

An average of 800 Washington State children age birth through 17 years die each year. Because children are a precious resource, the community seeks to understand how and why these children die, and use that knowledge to prevent other child deaths. Participation by many individuals and groups is needed to accurately identify contributing factors in child deaths and carry out prevention efforts. Child death review (CDR) is a nationally recognized tool for collecting and acting on information to prevent deaths of children.

After several years of joint work by the Washington Department of Health (DOH) and Department of Social and Health Services (DSHS), a 1997 Governor's Initiative funded DOH to plan and implement a comprehensive child death review system for our state. DOH and DSHS created a system that addresses prevention focuses of both agencies. This included the development of community-based teams and a statewide system for support, training, and collection / analysis of child death review generated data.

DOH administers the funding for the local Child Death Review teams and provides: overall management of the program, technical assistance to local teams; and epidemiology-focused data analysis. DSHS provides leadership for integration of CDR into its statewide child welfare services; assures the participation of Child Protective Services on local CDR teams; and receives / reviews / responds to team recommendations.

In Washington, the Child Death Review program focuses on unexpected deaths of children age birth through 17. Of the $500,000 annual budget for CDR, $350,000 goes to local health jurisdictions for coordination of local teams. The remaining $150,000 supports the state system that gathers, aggregates and assesses information from local reviews, provides technical assistance to local teams; and promotes prevention recommendations.

The Washington State Child Death Review Committee guides the overall activity of the state's child death review initiative. The committee is co-chaired by office directors of both DOH and DSHS Children's Administration. Members are representatives of state agencies and organizations concerned with the health and safety of children.

Since 1998, thirty (30) Child Death Review teams have formed, encompassing the entire state. These teams are multi-disciplinary, with representatives from community agencies concerned with the health and safety of children.

In 1999, 751 deaths occurred to Washington residents age birth through 17 of which an estimated 375 were unexpected. Local teams completed more than 260 reviews and submitted information to DOH from 229 of those reviews. Not all unexpected deaths for 1999 were reviewed because widespread data collection for the CDR program was not implemented until mid-year 1999.

Of the reviews completed in 1999, the CDR teams considered 59% were preventable. Based on information gathered in reviews, teams made recommendations for system improvements; policy concerns; and prevention strategies. See complete Data Report (Appendix 1) for details.

Fifty-nine percent of the 1999 unexpected childhood deaths reviewed by CDR teams were considered preventable.

Some of the CDR teams have already implemented local initiatives as a result of the reviews they have conducted. The following are but a few of the activities undertaken:

- The Yakima County CDR team sponsored a workshop entitled "Your Role After an Infant Death: Resources for Professionals and Communities" that was attended by 95 people (EMTs, fire fighters, police, coroners, PHNs, funeral directors, ER personnel, physicians, etc.).
- A letter from the Whatcom County CDR team to a local ski area about the danger of out-of-bounds skiing resulted in large signs being posted to warn of that danger.
- The King County CDR team sent a letter to the Mayor, Police Chief, and City Council advocating for revision to the regulations governing swimming in the ship canal due to the severe risk posed by boat traffic.
- In preparation for conducting CDR, the Grant County team reviewed several years of death certificates for children. As a result, a multi-agency collaboration for drowning prevention was begun. Grant County has a large amount of recreational water, shoreline and canals.

In conclusion, the uniqueness of Washington's Child Death Review program lies in its community based multi-disciplinary review teams and the consistent data elements collected from each review. Existing data on causes and incidence of child fatalities is not sufficient to fully understand the circumstances surrounding most child deaths, nor do they provide the details needed to make local and state data-driven policy recommendations.

CDR community teams foster an environ-ment for interagency and interpersonal commitment to prevent future deaths to children.

The community review process not only generates the information needed to better understand why a child died, it also fosters, at both the local and state level, an environment for inter-agency and inter-personal commitment to prevent future deaths of Washington State's children.

Introduction

In spite of a declining child death rate, due to such factors as advances in medical care, improvements in environmental safety, and injury prevention education, there are still many child deaths that can be prevented. Preventing these deaths requires 1) recognition of the complex circumstances (co-factors) that contribute to the causal event and 2) broad-based community commitment to activities that mitigate such circumstances.

Child death review is a nationally recognized tool to prevent deaths of children.

Child death review is a nationally recognized tool for collecting and acting on information to prevent deaths of children. Forty-five states have child death review programs. Program structure and funding vary widely but all have a common goal – to reduce preventable deaths of children by:

- collecting and reporting accurate, uniform information,
- identifying circumstances leading to such deaths,
- improving interagency communication, and,
- developing strategies to improve child health and safety.

After several years of joint preparation by the Washington State Department of Health (DOH), the Department of Social and Health Services (DSHS) and community advisors, the Governor included funding in the 1997-99 Biennial Budget to develop and implement a comprehensive child death review system for Washington. The initiative specified the development of community-based teams and a statewide system for support, training, and collection / analysis of child death review generated data.

In Washington, the Child Death Review (CDR) program focuses on unexpected deaths of children age birth through 17. Child death review in this state is a retrospective, post-investigation process. Teams, made up of representatives of community agencies and professions, review information known about the causes, circumstances, and contributing factors in a child's death. The purpose of the review is to identify preventable circumstances contributing to the death and make recommendations for actions that address those circumstances and thus help improve the health and safety of all children. Work of the CDR team is confidential, protected from subpoena or discovery, and may not be introduced into evidence in civil or criminal proceedings (RCW 70.05.170)

CDR teams make recommendations for actions that help improve the health and safety of all children.

A high quality statewide child death review system allows a maximum of local autonomy while assuring that certain procedures and methods are standardized so that information can be consolidated at the state level, comparisons may be made among local areas, and lessons learned in one area may be considered for application elsewhere.

CDR work is confidential, protected from subpoena or discovery. RCW 70.05.170

Of the $500,000 annual budget for Child Death Review, $350,000 is contracted to local health jurisdictions for development and coordination of local CDR teams. The remaining $150,000 supports the DOH system that gathers, aggregates and assesses information from local reviews, provides technical assistance to local teams; and promotes prevention recommendations.

State Leadership

Representatives of the state Department of Health and the Department of Social and Health Services have been developing a shared vision for child death review for several years. In 1993, the legislature authorized local health jurisdictions to conduct child mortality reviews on a voluntary basis and some jurisdictions have been conducting reviews since then. At the same time, DSHS Children's Administration began using regional committees to review deaths of children who had received Child Protective Services in the year prior to their death.

When the legislature provided funding to DOH in 1997 for the development of a comprehensive, statewide system of child death review, the two agencies built on their earlier collaboration to create a system that integrated the public health and social service prevention focuses of both organizations.

Representatives of WA DOH and DSHS have a shared vision for a common child death review system that addresses both public health and social services responsibilities.

DOH administers the funding for the local Child Death Review teams; provides overall management of the program; provides technical assistance to local teams; and provides epidemiology-focused data analysis based on the work of local teams. The Director of DOH Maternal Child Health Office co-chairs the Washington State Child Death Review Committee.

DSHS provides leadership for integration of child death review into its statewide child welfare services; assures the participation of Child Protective Services staff on local CDR teams; and receives/reviews/ responds to team prevention recommendations. The Director of DSHS/DCFS Program and Policy Office co-chairs the Washington State Child Death Review Committee.

The Washington State Child Death Review Committee guides the overall activity of the state's child death review initiative. Its' charge is to:

- advise DOH and DSHS on development of the statewide child death review process,
- review information aggregated from local child death reviews,
- identify statewide issues,
- make recommendation for changes in policies, practices and laws that impact the health and safety of children, and
- facilitate cooperation among state and federal agencies.

Committee membership includes representatives of the state agencies and organizations concerned with the health and safety of children.

Local Child Death Review Teams

DOH began funding the development of local teams in state fiscal year 1998. Over the next two years, every county in the state implemented a child death review process. There are now 30 Child Death Review teams, each reviewing deaths of child residents of their county(s).

Team composition varies from community to community but each has core members including public health, Child Protective Services, Medical Examiner / Coroner, medical / emergency provider, social services / mental health, prosecutor, and law enforcement. Teams may also have representatives from other community services. See Appendix for membership rosters and a list of local Child Death Review team activities.

Results

Child Death Review Team Findings: A Summary from the Report on Reviews of 1999 Deaths

(See Appendix 1 for Full Report)

The state Child Death Review (CDR) program seeks to gather information on all unexpected deaths of children from birth through age 17, except those unexpected deaths that are due to extreme prematurity. When an unexpected child death occurs, local teams gather data from as many relevant sources as possible in order to gain a complete picture of the circumstances surrounding the death. They meet to review all the information and to reach conclusions regarding the child's death. In particular, they look at whether the death was preventable and what strategies might be used to prevent deaths such as these in the future. Data

from the reviews are submitted to the state CDR program at the Washington State Department of Health.

There are several data limitations that need to be mentioned. Because widespread data collection for the CDR program was not implemented until mid-year in 1999, not all unexpected deaths for 1999 were reviewed. Additionally, not every active team submitted completed reviews for 1999 to the state database and in some cases, there are problems with the quality of the data (summarized in the appendix). Finally, as the numbers are small and do not represent a complete year of data, caution should be used when interpreting the 1999 CDR data and using it to represent statewide or local death estimates.

- In 1999, based on preliminary death certificate data, 751 deaths occurred to Washington residents ages 0-17. The majority of the deaths (72%) were due to "natural" causes.[1]

- Local teams participating in Washington's CDR program completed 269 reviews of deaths occurring to residents ages 0-17 of Washington State in 1999.

Table 1: Total Number of 1999 Deaths to Washington Residents Ages 0-17 and Deaths Reviewed by 1999 Teams, by Manner of Death[1]

	Vital Records*	CDR Reviews	% Reviewed
Natural	538	115	21.4
Accident	152	103	67.8
Suicide	27	25	92.6
Homicide	31	20	64.5
Undetermined	3	6	--
Total	751	269	35.8

Source: CDR Database

- Of the 269 reviews of 1999 deaths, teams submitted 229 completed reviews of child deaths to the state CDR database. These 229 reviews were submitted from twenty-six counties. Among the deaths reviewed, 66% were males and 34% were females.

- Of the 229 deaths reviewed, 76 (33%) of the families had at least one referral to Child Protective Services (CPS) and 52 (23%) had at least one investigation. Fifty-one of the deaths reviewed (22%) were classified as Department of Social and Health Services (DSHS) cases. In 1999, a review was classified as a DSHS case based on whether DSHS considered it a "case." Starting in October 2000, a review was classified as a DSHS case if

[1] Manner of death is reported on the death certificate. "Natural" death refers to deaths that occur due to Sudden Infant Death Syndrome (SIDS), diseases and other syndromes. "Accident" refers to deaths due to unintentional injuries. Because the manner of death in Vital Records may be changed after review at the end of the year, the manner of death at the time of the team review may not be the same as the Vital Records final determination.

the child or their family had contact with Children's Administration at DSHS during the 12 months prior to the child's death.

- Sudden Infant Death Syndrome (SIDS) and vehicular deaths accounted for the two greatest distinct circumstances of death in the 1999 reviews in the CDR database. Some specific data elements for deaths from Other Circumstances, SIDS, Motor Vehicle Crashes, Firearms, Suicides and Drowning are summarized in the full report in Appendix 1.

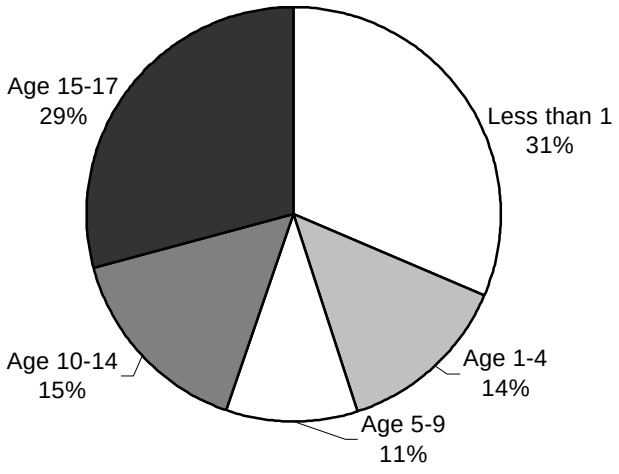
Table 2: Number and Percent of Deaths by Circumstance in 1999 CDR Database (Deaths Reviewed and Reported as of 12/00)

Circumstances of Death*	Number	Percent
Other	65	28.4
Sudden Infant Death Syndrome	54	23.6
Vehicle	49	21.4
Firearm	22	9.6
Drowning	19	8.3
Fire	11	4.8
Fall	7	3.1
Poison	5	2.2
Burn	5	2.2

**may check more than one* *Source: CDR Database*

- The age groups with the largest number of reviews for 1999 were age < 1 and ages 15-17.

Figure 1: Percent of 1999 Deaths Reviewed and in the state CDR Database by Age Groups



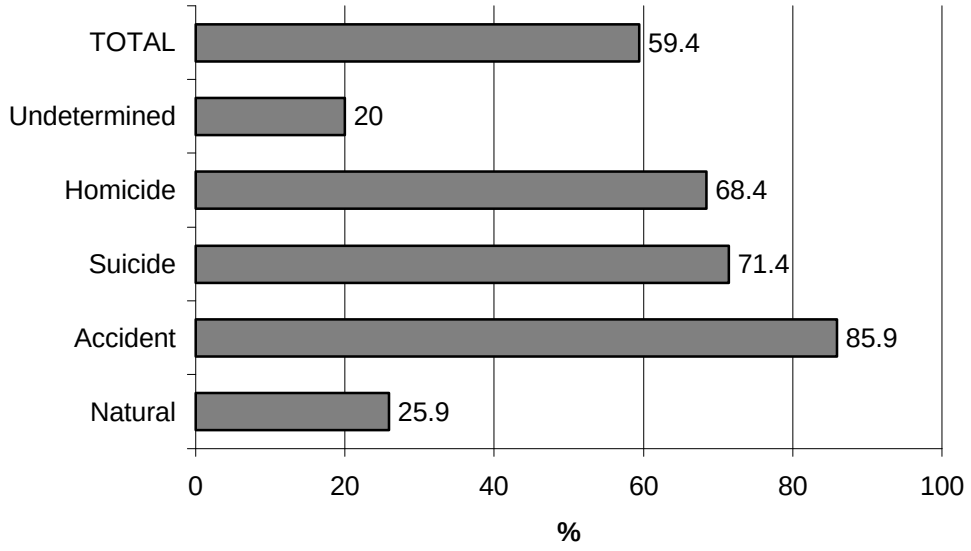
Source: CDR Database

Prevention

A death was considered preventable if reasonable medical, educational, social, legal or psychological intervention could have prevented this death from occurring. A "reasonable" intervention is one that would have been possible given known circumstances and resources available.

The teams determined that the death was preventable in 59% of the cases reviewed, not preventable in 18%, and unable to determine in 18%. This section was left unanswered in 5% of the reviews.

Figure 2: Percent of Deaths Determined by Teams to be Preventable, by Manner of Death, 1999 CDR Reviews



Source: CDR Database

Recommendations on system improvements were made in 28% of the reviews, policy improvements in 30%, and prevention strategies in 61%.

Of the 229 reviews completed in 1999, recommendations on system improvements were made in 58 reviews (28%), and on policy issues in 65 reviews (30%). Prevention strategies were proposed in 61% of the reviews.

Education was the most frequently recommended type of prevention strategy, followed by changes to current practices, new services, legislation, and community safety.

Table 3: Prevention Strategies Proposed in 1999 Reviews

Type of Strategy	Number of Times Recommended
Education	145
Change in Current Practices	28
New Services	22
Legislation	19
Community Safety	10
Other Program Recommendations	9
Increase in Funding	9
Improve Communication	9
Enforcement	8
Product Safety Action	5

Examples of Recommended Prevention Strategies Listed by Circumstance or Manner of Death

Burn

- DOH routine health education mailings (Child Profile) should include messages about the importance of supervision of young children in the kitchen and about positioning pots with the handles turned inward and on burners away from the reach of children.

Drowning

- The WA State Medical Association or the Epilepsy Foundation could educate providers, patients and school nurses about the hazards of baths for individuals with epilepsy.

- Develop WA State regulatory standards for drowning prevention at bathing beaches. Codes exist for all the other bodies of water except bathing beaches. This regulation could address factors that were at work in this drowning (e.g. in-service training and a lifeguard response time of less than 30 seconds for life threatening instances).

Suicide

- Promote better awareness of and outreach to depressed or suicidal teens.

Recommendation: Educate … about the differences between typical adolescent behavior and behaviors indicating a need for mental health evaluation.

- Educate school and other staff working with youth and parents about the differences between typical adolescent behavior and behaviors indicating a need for mental health evaluation.

Vehicular

- Increase funding for traffic safety education programs, taught by law enforcement agencies, to every middle and high school student in

Washington State. This curriculum would include the dangers of driving under the influence of drugs and alcohol.

- Increase compliance checks to assure that vendors aren't selling alcohol to minors.

Fire

- Encourage CPS to make fire detector and wood stove installation checks standard procedures prior to adoption of children (as done for foster care).

- Conduct public education campaign on the importance of having a family fire plan, checking smoke alarm monthly, replacing alarm every 10 years, having installation of wood stoves done to code.

Firearms

- Increase training of adults who interact with youth via the "Gatekeeper" training through the Washington State Youth Suicide Prevention Program so that more will recognize the warning signs for suicide.

- Promote legislation that requires safe storage of firearms.

Sudden Infant Death Syndrome

- Ongoing public education via the SIDS Foundation of WA's "Communities for Infant Sleep Position Coalition" is needed to educate infant caregivers about the importance of a safe sleep environment and not using soft bedding. The need for education is continuous.

Recommendation : Ongoing public education about the importance of a safe sleep environment.

- Have more bilingual videos, nurses, and materials available to educate women whose first language is not English

Evaluation Plan

In collaboration with evaluation experts at the University of Illinois at Chicago, DOH has developed an evaluation framework with measurable process and outcome measures based on the CDR program objectives. As part of that evaluation, a survey of all local team members and team coordinators on perceptions of the CDR process was implemented in December 2000.

Local teams report improved communica-tion and practice among agencies involved in the CDR process.

Based on survey results, 57% of team members and 77% of team coordinators reported that the quality of communication among agencies in their communities has improved as a result of participation in the CDR process. This survey will be repeated in the future to measure ongoing progress towards the objectives.

Additionally, data from the state database will be used to look at other issues such as access to records and development of team prevention recommendations.

Emerging Issues

Over the past two years, we have identified challenges as well as successes for the Washington child death review system. As we move towards our program objectives, issues emerge that need continuing attention. Examples:

- From the beginning, a primary program goal has been a review process that is uniform enough to identify the same types of information for all reviews yet allow for local differences. To that end, a Policy and Procedures Guidelines was developed for local teams that offers suggestions for convening teams and conducting reviews. The Guidelines will be revised based on ongoing feedback from teams.

- At the state level, DOH and DSHS Children's Administration work together to maintain one system of child death review that serves the needs of both agencies. This requires constant maintenance because of shifting foci and staff in both agencies.

- The WA State Child Death Review Committee is a forum for state level communication among agencies concerned with the health and safety of children. This group is beginning to address common concerns raised by Child Death Review.

- Uniform review requires that all teams have access to the same types of information. Access to such information varies from county to county and is dependent on local interpretation. DOH is requesting guidance from the Washington State Attorney General's office as to the laws governing release of information for the purposes of public health review of child deaths.

- Although there are preliminary data from 1999, reviews of child deaths occurring in the year 2000 will provide the first full year of data from the Child Death Review program. Aggregate data analysis that will inform state child death prevention recommendations is just beginning.

- At the local level, CDR teams are recommending needed changes to legislation, policy and practice. Some of these recommendations confirm already identified injury prevention concerns and are being implemented locally. Others are population-based concerns and will be given added weight by repeated reviews that highlight the same concern in more than one county.

At the local level, CDR teams are recommending needed changes to legislation, policy, and practice.

- The year 2000 will be the first full year of data collection. When that data are analyzed, the first Annual Report for Washington State's Child Death Review Program will be produced. The report will include recommendations for changes to legislation, policy and practice, based on assessment of the many variables (circumstances) identified in the reviews.

Summary

Child Death Review is now fully implemented across the State of Washington. The comprehensive data collected through local reviews will be used by many organizations and individuals who are concerned about the health and safety of Washington's children such as injury prevention, SIDS prevention, child protection, public safety, and preventative health care.

Other states report, as a result of the child death review process, legislation to address hazards to children, better-targeted safety education, improved cooperation among participating agencies and increased support for quality death investigation.

Other states that have had programs in place for several years tell us that child death review has led to improvements in the systems that safeguard the lives of children. Examples of positive changes include: legislation to address the most serious hazards to children; better-targeted state and local safety education; generally improved cooperation among agencies participating on community review teams, and increased support for quality death investigation. We are looking forward to reaping similar benefits from Washington's child death review effort.

Appendix One

Child Death Review Team Findings

A Summary from the Reviews of 1999 Deaths

The Washington State Child Death Review (CDR) program seeks to gather information on all unexpected deaths of children from birth through age 17, except those unexpected deaths that are due to extreme prematurity. When an unexpected child death occurs, local teams gather data from as many relevant sources as possible in order to gain a complete picture of the circumstances surrounding the death. They meet to review all the information and to reach conclusions regarding the child's death. In particular, the teams look at whether the death was preventable and what strategies might be used to prevent deaths such as these in the future. Data from the reviews are submitted to the state CDR program at the Washington State Department of Health. Based on policies in place, data in the state CDR database are considered confidential and will only be released in an aggregated, non-identifiable form.

Widespread data collection for the CDR program was implemented mid-year in 1999. In 1999, based on death certificate data, 751 deaths occurred to Washington residents ages 0-17. The majority of the deaths (71%) were due to "natural" causes. Local teams participating in Washington's CDR program completed 269 reviews of deaths occurring to Washington residents ages 0-17 in 1999. There are several data limitations that need to be mentioned. Because widespread data collection for the CDR program was not implemented until mid-year in 1999, not all unexpected deaths for 1999 were reviewed. Additionally, not every active team submitted completed reviews for 1999 to the state database and in some cases, there are problems with the quality of the data. Finally, as the numbers are small and do not represent a complete year of data, caution should be used when interpreting the 1999 CDR data and using it to represent statewide or local death estimates.

Of the 269 completed reviews from 1999 deaths, 229 were submitted to the state CDR database. These 229 reviews were submitted from twenty-six counties. Among the deaths reviewed, 152 (66%) were males and 77 (34 %) were females. Of the 229 deaths reviewed, 76 of the families had at least one referral to Child Protective Services (CPS) and 52 had at least one investigation. Fifty-one of the deaths reviewed were Department of Social and Health Services (DSHS) cases. In 1999, a review was classified as a DSHS case based on whether DSHS considered it a "case." Starting in September 2000, a review was classified as a DSHS case if the child or their family had contact with Children's Administration at DSHS during the 12 months prior to the child's death.

Table 1: Total Number of 1999 Deaths to Washington Residents Ages 0-17 and Deaths Reviewed by 1999 Teams, by Manner of Death[1]

	Vital Records	CDR Reviews	% Reviewed
Natural	538	115	21.4
Accident	152	103	67.8
Suicide	27	25	92.6
Homicide	31	20	64.5
Undetermined	3	6	--
Total	751	269	35.8

Demographics of children whose deaths were reviewed and submitted to the state database in 1999 are compared to state demographics in the following table.

Table 2: Race/ Ethnicity and Age Characteristics of 1999 child deaths reviewed by local teams and submitted to the state database, compared to the state population

	Total WA State, Ages 0-17 (Number)	Total WA State, Ages 0-17 (Percent)	1999 CDR Deaths in Database (Number)	1999 CDR Deaths in Database (Percent)
Race/ Ethnicity*				
White	1,317,794	86.0	173	75.5
African American	69,527	4.5	28	12.2
Native American	38,467	2.5	11	4.8
Asian/ Pacific Islander	105,675	6.9	18	7.9
Unknown			2	0.9
Hispanic	139,967	9.1	27	11.8
TOTAL (Race only)	1,531,463		229	
Age				
Less than 1	77,287	5.0	72	31.4
1-4	322,228	21.0	31	13.5
5-9	449,519	29.4	24	10.5
10-14	434,388	28.4	35	15.3
15-17	248,041	16.2	67	29.3
TOTAL	1,531,463		229	

**more than one race/ethnicity may have been provided.*

[1] Manner of death is reported on the death certificate. "Natural" death refers to deaths that occur due to Sudden Infant Death Syndrome (SIDS), diseases and other syndromes. "Accident" refers to deaths due to unintentional injuries. Because the manner of death in Vital Records may be changed after review at the end of the year, the manner of death at the time of the team review may not be the same as the Vital Records final determination.

Table 3: Characteristics of 1999 Child Deaths reviewed by local teams and submitted to the state database

	Number (N=229)	Percent (100%)
Manner of Death		
Natural	85	37.1
Accident	99	43.2
Suicide	21	9.2
Homicide	19	8.3
Undetermined	5	2.2
Circumstances of Death*		
Other	65	28.4
Sudden Infant Death Syndrome	54	23.6
Vehicle	49	21.4
Firearm	22	9.6
Drowning	19	8.3
Fire	11	4.8
Fall	7	3.1
Poison	5	2.2
Burn	5	2.2
Health Insurance		
Private	19	8.3
Medicaid	43	18.8
Basic Health Plan	3	1.3
Other	9	3.9
None	1	0.4
Unknown	154	67.2
Other Characteristics		
Known Physical Abuse	9	3.9
Known Emotional Abuse	2	0.9
Known Sexual Abuse	1	0.4
Known Neglect	17	7.4
Physical disability	17	7.4
History of Family Violence	29	12.7

**May check more than one*

Time Injuries Occurred

Based on data from the 1999 reviews, the hours between 1 pm and 6 pm and between 10 pm and 11pm were the most likely time for an injury leading to a death to occur. The number of accidental deaths in the 1999 CDR database peaked between 10 pm and midnight, while suicides peaked from 1-3 am and 4-6 pm and homicide deaths had several peaks. Caution should be used when interpreting these results due to small numbers.

Figure 1: Number of Deaths in CDR Database by Hour Injury Occurred, 1999 Reviews

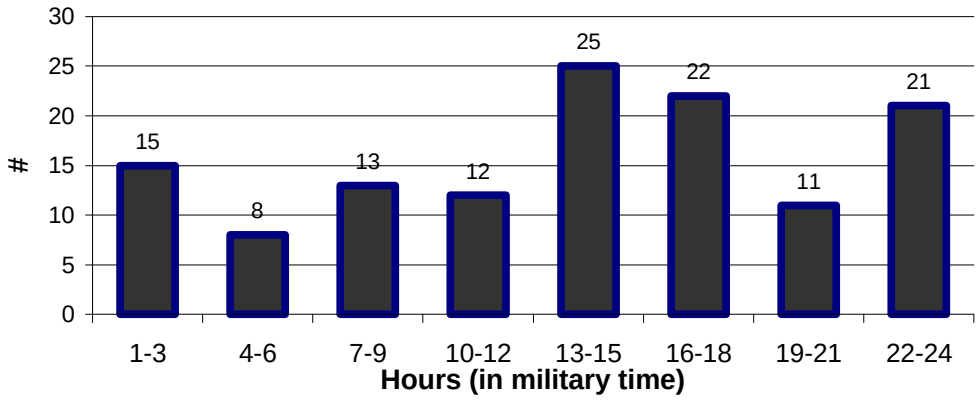
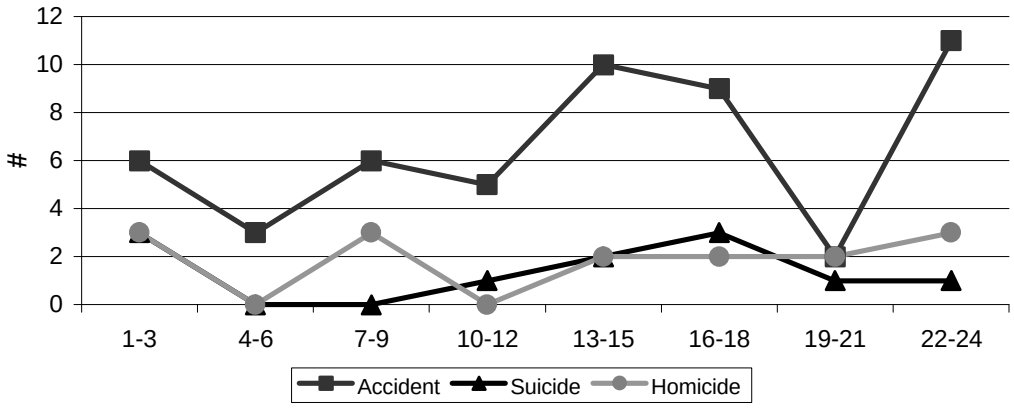


Figure 2: Number of Deaths in CDR Database by Hour Injury Occurred and Manner of Death, 1999 Reviews



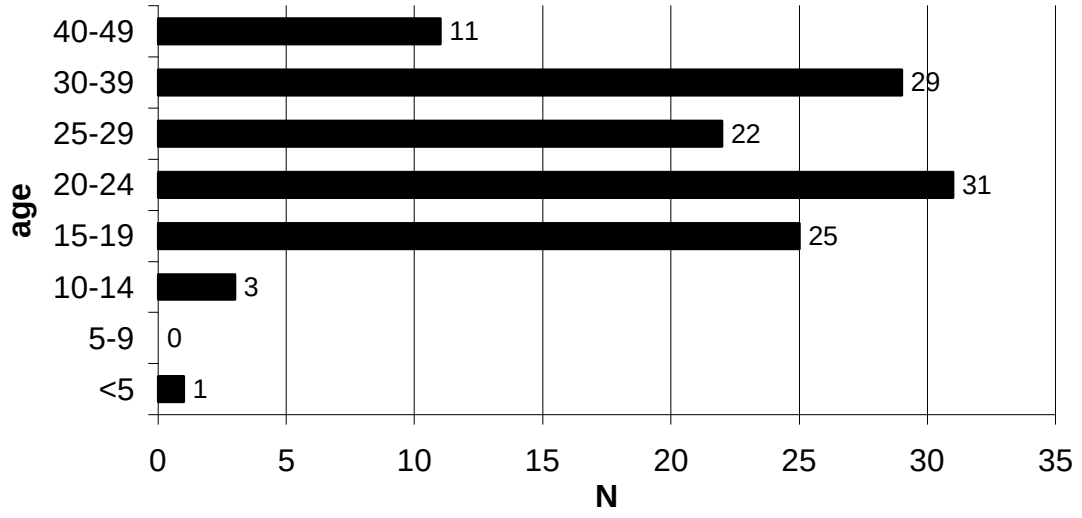
Supervision

The reviews included information on supervision at the time of injury. Of the 229 reviews from 1999 in the CDR database, the majority of the children were supervised by a parent at the time of injury or death. Supervision was reported as follows:

- 106 were supervised by a parent,
- 10 were supervised by other relatives,
- 9 were supervised by a sibling,
- 8 were supervised by a friend,
- 3 each were supervised by the Mother's boyfriend / girlfriend or institutional staff,
- 2 each were supervised by a foster parent, licensed child care worker, or acquaintance,
- 1 child each was supervised by a babysitter or stranger, and
- "Other" individuals supervised eleven of the children.

This excludes 58 reviews where supervision was considered "not applicable" and 13 where supervision was unknown. Five of the supervisors reportedly appeared to be under the influence of alcohol; 3 under the influence of drugs; 3 appeared to be mentally ill; 1 was developmentally disabled; 2 had another disability. Sixty of the supervising people were teens or young adults.

Figure 3: Age of Supervisor at time of Child's Injury/ Death, 1999 Reviews



** Excludes 80 Unknown or missing , 47 where age "not applicable."*

Child Abuse and Neglect

In the team conclusions, physical abuse was felt to be a factor in seven (3.1%) of the deaths, neglect was considered to be a factor in twenty-three (10.0%) of the deaths, and delayed or inadequate care was a factor in nine (3.9%) of the deaths.

Table 4: Number of Deaths by Manner and Circumstances of Deaths Where Physical Abuse, Neglect, or Delayed Inadequate Care were Cited by Committees as a Factor in the Death, CDR 1999 Deaths

	Abuse (n=7)	Neglect (n=23)	Delayed or Inadequate Care (n=9)
Manner of Death			
Natural	0	3	2
Accident	1	16	2
Suicide	0	2	0
Homicide	6	2	5
Total	7	23	9
Circumstances of Death*			
Vehicle	1	7	0
Firearm	1	1	0
Drowning	0	5	0
Fire	0	1	0
Fall	0	0	0
Poison	0	1	3
SIDS	0	2	0
Burn	0	3	0
Other	5	8	6
Total	7	28*	9

** May check more than one circumstance.*

The following pages offer a more detailed summary of 1999 reviewed deaths by some of the circumstances and manner of death (for circumstances of deaths where there are a larger numbers of reviews). In future reports with greater numbers of reviews, DOH will be able to include detailed summary information for all circumstances of deaths.

Other Circumstances of Death

In the 1999 reviews, there were 65 deaths where the circumstance of death was classified as "other." The "other" category includes unexpected deaths that either do not fit into the listed categories (ex. hanging deaths, deaths from infectious disease or asthma), or deaths that are due to another listed cause but have additional circumstances (ex. a drowning where the deceased also had a seizure). Thirty-five (57%) of deaths in this category were to males and 26 (43%) to females. Teams determined that 28 of these deaths (43%) were preventable.

Table 5: Details of Reviews Included as "Other" Circumstances of Death

	Number (N=65)	Percent (100%)
Category		
Respiratory	29	44.6
Injury	13	20.0
Neurological	8	12.3
Cardiovascular	5	7.7
Infectious Disease	4	6.2
Sudden Death, Undetermined	3	4.6
Other	2	3.1
Congenital Anomalies	1	1.5
Manner of Death ("Other" Circumstances)		
Natural	31	47.7
Accident	15	23.1
Suicide	9	13.8
Homicide	8	12.3
Undetermined	2	3.1

Sudden Infant Death Syndrome (SIDS) Deaths

Sudden Infant Death Syndrome (SIDS) is "the sudden death of an infant under 1 year of age which remains unexplained after a thorough case investigation, including performance of a complete autopsy, examination of the death scene, and review of the clinical history."[1] Some studies have identified risk factors associated with SIDS which include sleeping on the stomach, sleeping with someone (co-sleeping), and secondhand smoke. CDR reviews include information on all of these risk factors, although caution

[1] "Assessment of Infant Sleeping Position -- Selected States, 1996, " Morbidity and Mortality Weekly Report: October 23, 1998 / 47(41);873-877

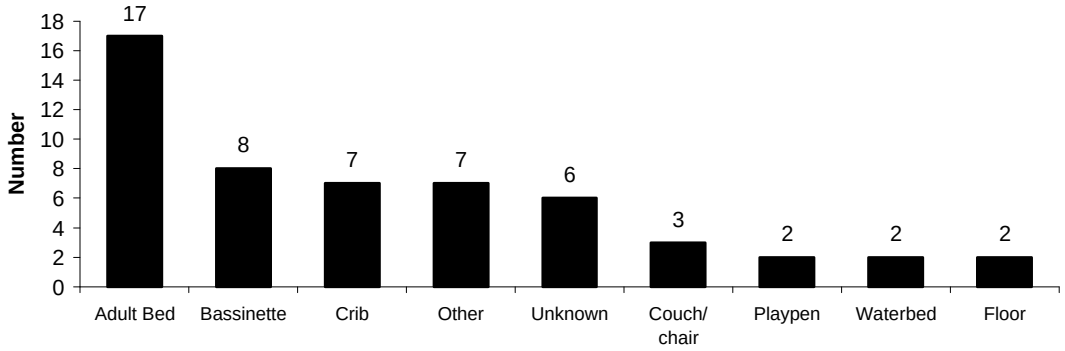
should be used in interpreting these results due to the large proportion of missing data for some of these variables.

Of the 54 SIDS deaths from 1999 reviewed, 30 were male infants and 24 were female infants. Risk factor information is summarized below.

- Sleeping position: In the deaths where sleeping position of the infant was known, 60% of the infants were found lying on their stomachs, 21% were found lying on their backs, and 19% were on their sides.
- Co-Sleeping: In the deaths where co-sleeping (sleeping with another person) of the infant was known, 58% were reported to be co-sleeping. Of those who were co-sleeping, 81% were sleeping with a parent.
- Location: 44% percent were found in an adult bed, couch, waterbed, or floor, while 32% were found in their cribs, a bassinette or a playpen.
- Firmness of sleeping Surface: In the deaths where firmness of sleeping surface was known, 52% of the infants were found sleeping on an average or firm surface and 48% were sleeping on a soft surface.
- Exposure to Tobacco Smoke: In the deaths where tobacco smoke exposure of the infant was known, 45% were exposed to environmental smoke.
- Recent Health Status: In the deaths where recent health status of the infant was known, 50% were reported to be unhealthy in the last two weeks of life. The majority of those infants reported to be unhealthy had respiratory symptoms in the two weeks previous to their deaths.

These SIDS deaths were considered preventable in 36% of the reviews, not preventable in 24% of the reviews, and the teams were unable to determine preventability in 40% of the reviews.

Figure 4: Number of SIDS Deaths by Location When Found, 1999 Reviews



Vehicular Deaths

Of the forty-nine 1999 vehicular deaths reviewed and submitted to the state database, 35 (71%) were to males and 14 (29%) were to females. Approximately one-third of the deaths occurred on a rural road, one quarter on a highway and one quarter on a city street. Speed and driver error were the most commonly cited contributing factors. The majority of drivers were below the age of twenty. Forty-two (86%) of these deaths were determined by teams to be preventable.

Table 6: Characteristics of 1999 Vehicular Deaths Reviewed and in State CDR Database

	Number (n=49)	Percent (100%)
Location of Injury*		
Rural road	17	34.7
City street	12	24.5
Highway	11	22.4
Off road	5	10.2
Shoulder	5	10.2
Intersection	4	8.2
Driveway	2	4.1
Water	1	2.0
Other	2	4.1
Contributing Factors*		
Excess speed	26	53.1
Driver error	27	55.1
Alcohol or drug Intoxication	12	24.5
Adverse weather conditions	3	6.1
Other	10	20.4
Age of Driver		
14-15	5	10.2
16-17	17	34.7
18-19	6	12.2
20-24	1	2.0
25-29	3	6.1
30-34	4	8.2
35-45	1	2.0
46-54	0	0.0
>55	1	2.0
Unknown/ Missing Data	11	22.4
Age of Deceased		
Less than 1	2	4.1
1-4	4	8.2
5-9	6	12.2
10-14	15	30.6
15-17	22	44.9

**Numbers may exceed 49 as teams were asked to checked all that apply.*

Airbags: Seven of the children were sitting in seats with an airbag present (their ages were less than 1, 3, 5, and four children were age 17). Two of the children were reported injured by a deploying airbag.

Seatbelt usage: Of the 49 vehicular-related deaths, seven involved pedestrians or bicycle riders. Of the 42 remaining vehicular deaths, teams reported that seatbelts were present in 38 of the vehicular deaths (data on seatbelt presence were missing in three of the 42 deaths, and one child was riding in the back of a pick-up truck). In those 38 cases where the seatbelt was present, it was in use in 7 (18%) of the deaths reviewed, not in use in 25 (66%) of the deaths reviewed, and information on use was missing in the remaining 6 (16%) of the deaths reviewed. In the deaths of infants ages less than age two, an infant seat was present in three of the vehicular deaths, and in use in two of those deaths.

Because of the nature of these data, it is not possible to infer anything about the role that these prevention devices may have had in the deaths of these children. It is possible that some children may have been injured by these devices, particularly if there was a problem with improper use (such as an improperly installed infant seat). It is also possible that a prevention device may be inadequate to prevent fatal injury in some circumstances (such as when a smaller passenger car is struck by a larger and heavier vehicle traveling at high speed).

Drowning Deaths

There were nineteen children whose deaths were attributed to drowning in the state CDR database for 1999. Fifteen (79%) were males and 4 (21%) were females. The majority of deaths occurred in a lake or river. In six of the deaths, the child was known to not be able to swim. Flotation devices were lacking in all instances (in 14 reviews they were not present and in 5 reviews they were reported to be not/applicable). A lifeguard was present in one of the deaths. Sixteen of these deaths (84%) were determined by teams to be preventable.

Table 7: Characteristics of 1999 Drownings Reviewed and in State CDR Database

	Number (N=19)	Percent (100%)
Age		
Less than 1	1	5.3
1-4	3	15.8
5-9	5	26.3
10-14	2	10.5
15-17	8	42.1
Place of Drowning		
Lake	7	36.8
River	5	26.3
Bath tub	2	10.5
Hot tub/spa tub	1	5.3
Wading pool	1	5.3
Bucket	1	5.3
Other	2	10.5
Activity at time of drowning		
Boating	3	15.8
Swimming	2	10.5
Playing in the water	3	15.8
Playing near the water (beach, dock)	2	10.5
On a rubber raft or inner-tube	1	5.3
In vehicle	3	15.8
Bathing	2	10.5
Other	3	15.8
Previous Swimming Lessons		
Yes	2	10.5
No	5	26.3
Unknown	9	47.4
Other	3	15.8
Could Swim		
Yes	4	21.0
No	6	31.6
Unknown	6	31.6
Other	3	15.8

Firearm- Related Deaths

Of the 22 firearm deaths from 1999 that were reviewed and submitted to the state database, 73% were to males and 27% to females. These deaths were determined by the teams to be preventable in 19 (86%) of the reviews. Teams were unable to determine preventability in 1 review (preventability data were missing in two reviews). As illustrated in the table below, data elements were missing in many of the reviews submitted to the database.

Table 8: Characteristics of 1999 Firearm-Related Deaths Reviewed and in State CDR Database

	Number (N=22)	Percent (100%)
Age		
Less than 1	0	-
1-4	0	-
5-9	1	4.5
10-14	4	18.2
15-17	17	77.3
Manner of Death		
Natural	0	-
Accident	3	13.6
Suicide	10	45.4
Homicide	8	36.4
Undetermined	1	4.5
Pending investigation	0	-
Firearm Type		
Handgun	11	50.0
Rifle/ shotgun	8	36.4
Unknown	3	13.6
Gun Locked		
Yes	2	9.1
No	8	36.4
Unknown	9	41.0
Missing	3	13.6
Key Kept with Lock		
No	3	13.6
Unknown	11	50.0
Not Applicable	8	36.4
Ammunition Stored with Gun		
Yes	4	18.2
No	1	4.5
Unknown	17	77.3
Firearm Use at Time of Death		
Loading	1	4.5
Playing	1	4.5
Intent to Harm	16	72.7
Other	1	4.5
Unknown	3	13.6

Suicide Deaths

Of the 21 suicide deaths from 1999 reviewed and in the database, 19 (90%) were to males and 2 (10%) were to females. All but one suicide occurred in the 15-17 year old age range. The most frequently used method for suicide was firearms followed by asphyxia due to hanging. A majority of youth were known to have experienced a recent life crisis and more than one-third had recently spoken of suicidal thoughts. One decedent was a runaway and one had a friend who recently committed suicide. Six had a diagnosed mental health problem and three had received mental health services at some point. The most commonly cited life crises were troubles with girlfriends, dating or school / academic problems. These deaths were determined to be preventable in 14 (67%) of the reviews, not preventable in one (5%) review, and unable to determine in five (24%) reviews. Data on preventability were missing in one review. As illustrated in the table below, data related to the child's mental health history were unknown in many of the reviews submitted to the database.

Table 9: Characteristics of 1999 Suicides Reviewed and in State CDR Database

	Number (N=21)	Percent (100%)
Age		
Less than 1	0	-
1-4	0	-
5-9	0	-
10-14	1	4.8
15-17	20	95.2
Circumstances*		
Fall	2	9.5
Poisoning	2	9.5
Firearms	10	47.6
Asphyxia/ Hanging	7	33.3
Experienced Recent Life Crisis		
Yes	13	61.9
No	0	-
Unknown	7	33.3
Missing	1	4.8
Recently Spoke of Suicidal Thoughts		
Yes	8	38.1
No	4	19.0
Unknown	8	38.1
Missing	1	4.8
Ever Attempted Suicide		
Yes	2	9.5
No	6	28.6
Unknown	13	61.9

Access to Data

In every review, teams are asked to provide information on the data sources used to complete the review. In the 1999 reviews, death certificates were requested and received 99% of the time. Birth certificates were requested in 48% of the reviews, and received 87% of the time. The death scene investigation was requested in 65% of the reviews, and received 97% of the time. The medical examiner reports were requested in 77% of the reviews and received 100% of the time. Medical records were requested 38% of the time and received 99% of the time. In the 49 vehicular deaths reviewed, the motor vehicle crash report was requested in 35 (71%) cases. In the 54 SIDS deaths reviewed, the death scene investigation was requested in 38 (70%) of the reviews.

Team Recommendations

Of the 229 reviews completed in 1999, recommendations on system improvements were made in 58 reviews (25%) and were made on policy issues in 65 reviews (28%). Prevention strategies were proposed in 139 (61%) of the reviews.

Examples of System or Policy Issues Identified by Local Teams:

- Need for strict enforcement of driving laws and increased awareness of passenger safety
- Vehicular death scene investigation may be compromised when first responders transport obvious deaths from the scene.
- There is a need to clarify when first responders (medical personnel) shcould notify law enforcement.
- Excessive speed and not wearing a safety helmet are preventable risk factors.
- Child was riding unrestrained in vehicle with unlicensed driver.
- Need for functioning smoke detectors.
- More stringent laws needed for teenage drivers such as recent WA legislation will take effect July 2001.
- Adequate resources/shelters for homeless and abandoned teens - no shelters exist in most counties for such teens.
- Timely identification of physical abuse by emergency and primary care personnel.
- Suicide intervention program is needed in high schools to provide early identification of kids at risk for suicide.

Preventability

A death was considered preventable if reasonable medical, educational, social, legal or psychological intervention could have prevented this death from occurring. A "reasonable" intervention is one that would have been possible given the known conditions or circumstances and the resources available. The teams determined that the

death was preventable in 59% of the cases reviewed, not preventable in 17%, and unable to determine in 18%. This section was left unanswered in 5% of the reviews.

Table 10: Preventability of Deaths Reviewed by Manner of Death

	CDR Reviews	Preventable	Not Preventable	Unable to Determine
Natural	85	22	30	29
Accident	99	85	5	4
Suicide	21	15	1	5
Homicide	19	13	4	2
Undetermined	5	1	0	0
Total	229	136	40	42

Prevention Strategies

Education was the most frequently recommended type of prevention strategy, followed by changes to current practices, new services, legislation, and community safety. Examples of specific prevention strategies are included at the end of this report.

Table 11: Prevention Strategies Proposed in 1999 Reviews

Type of Strategy	Number of Times Recommended
Education	145
Change in Current Practices	28
New Services	22
Legislation	19
Community Safety	10
Other Program Recommendations	9
Funding	9
Improve Communication	9
Enforcement	8
Product Safety Action	5

Examples of Team Recommended Prevention Strategies by Circumstance or Manner of Death, 1999

Burn

- Child Profile mailings should include messages about the importance of supervision of young children in the kitchen and messages about positioning pots with the handles turned inward and on burners away from the reach of children.

Drowning

- Inform the public that any water is a safety hazard for young children.
- Promote water safety education, including to children (age appropriate material).

- The WA State Medical Association or the Epilepsy Foundation could educate providers, patients and school nurses about the hazards of baths for individuals with epilepsy.

- Develop WA State regulatory standards for drowning prevention at bathing beaches. Codes exist for all the other bodies of water except bathing beaches. This regulation could address factors that were at work in this drowning (e.g. in-service training and a lifeguard response time of less than 30 seconds for life threatening instances).

- Train guards to identify poor swimmers and assure that they are not permitted to swim in deep water unless they remain close to shore and lifeguards.

- Revise the Harbor Code to prevent swimming in the ship canal. Due to the high boat traffic (both commercial and leisure) through the canal, the committee agreed that swimming should be prohibited and posted as such in this area. Currently, law enforcement cannot cite swimmers in the canal because it isn't prohibited

Suicide

- Promote better awareness of and outreach to depressed or suicidal teens.

- A comprehensive health education curriculum for middle and high schools that would include suicide prevention training and risk reduction as well as deaths related to driving, drinking, swimming and violence, etc.

- Educate school staff, other staff working with youth and parents about the differences between typical adolescent behavior and behaviors indicating a need for mental health evaluation.

- Educate school staff and others working with youth about their responsibility to help youth get mental health services even if the parents are not seeking it for the child.

- Promote parental awareness of adolescent stress. Implement suicide prevention intervention training. Train the gatekeepers.

- The committee is concerned that the state just cut suicide prevention dollars by more than half. Sustained and funded prevention efforts are needed.

- Provide housing and outreach for teens in need. Foster care when the first signs of trouble came to the attention of authorities may make a difference.

Vehicular

- Increase funding for traffic safety education programs, taught by law enforcement agencies, to every middle and high school student in Washington State. This curriculum would include the dangers of driving under the influence of drugs and alcohol.

- Promote safer driving practices, observing speed limits

- Passive safety devices such as a divided highway on the Aurora Bridge.
- Encourage police agencies to carefully evaluate criteria for conducting a high speed chase, considering the risks to the alleged offender and innocent bystanders.
- Public safety messages in Child Profile mailings and in press releases about the importance of using seatbelts.
- Increase education / awareness about bike helmets and safe biking / observance of "road rules"
- Increase compliance checks to assure that vendors aren't selling alcohol to minors.
- Encourage the local high school to establish a Student's Against Drunk Driving (SADD) chapter to increase awareness about driver safety.
- Public Health should continue to coordinate with WA State Division of Alcohol and Substance Abuse (DASA) and the WA Traffic Safety Committee to reduce underage drinking.
- The local police department should review roads where fatal collisions have occurred to see if speed limits are posted, additional stop lights or signage about hazards could decrease the likelihood of speeding.

Fire

- Make sure landlords keep all rentals - in particular low rent "teenage houses" up to code in terms of fire alarms, wiring, etc.
- Encourage CPS to make fire detector and wood stove installation checks standard procedures prior to adoption of children (as done for foster care).
- Conduct public education campaign on the importance of having a family fire plan, checking smoke alarm monthly, replacing alarm every 10 years, having installation of wood stoves done to code.
- Consider providing free smoke alarms to low-income residents.
- Any government agency working with families should include a safety inspection that includes assessing for a properly installed / working smoke alarm
- Local fire departments need to have smoke detectors available and also install them when need is assessed.

Firearms

- Increase training of adults who interact with youth via the "Gatekeeper" training through the Washington State Youth Suicide Prevention Program so that more will recognize the warning signs for suicide.
- Distribute information to the school districts about the availability of "Gatekeeper" training.

- Promote legislation that requires safe storage of firearms.
- Improve public awareness of the seriousness of suicide threats.

Sudden Infant Death Syndrome

- Promote education about safe sleeping arrangements for infants and the effects of exposure to environmental tobacco smoke.
- Ongoing public education via the SIDS Foundation of WA's "Communities for Infant Sleep Position Coalition" to educate infant caregivers about the importance of a safe sleep environment and not using soft bedding. This need for education is continuous.
- Continue public education via messages in Child Profile and the SIDS Foundation of WA's coalition, "Communities for Infant Sleep Position," that emphasize safe sleep environment whether infant is sleeping alone or co-sleeping and the importance of not smoking near infants
- Have more bilingual videos, nurses, and materials available to educate women whose first language is not English.
- Ask public health nurses to get consent from families with infant deaths to allow prenatal records to be used for prevention education.
- Target all caregivers, not just parents; include the message that babies with reflux should be put on their backs with their heads slightly elevated; warn about the dangers of including too many blankets or pillows in the crib; train visiting nurses to ask questions that identify whether a parent may be resistant to placing baby on his/her back.
- Consider involving churches in the campaign -- as a way to target grandparents who were given different information when their children were infants.

Other

- Possible strategies for reducing childhood deaths from asthma would include education regarding the seriousness of asthma and the importance of ongoing well child care. Also work with CHILD Profile to provide messages about asthma and information about what to do if a child with asthma has a respiratory illness.
- There is a need to alert emergency room doctors and triage nurses about the signs and symptoms of serious gastrointestinal illness and shock. Perhaps encourage review of protocols for GI symptoms and shock in medical society newsletters.
- Public Health, CPS and other workers providing services for domestic violence families need ongoing training to assess the risk of physical harm to any children in the household.

- Address cross-cultural issues related to health and medical treatment of children. Continue to communicate and increase Public Health involvement with pregnancy and child care / development. (First Steps)
- Promote more accessibility to local medical foster care
- Improve communication between hospitals and local pediatrician when there is a question of child's welfare. Child welfare agency could affect this liaison.
- Have a death investigation form that can be used in the field - questions for law enforcement to look for and ask.
- Consider funding for mobile defibrillators for law enforcement to be able to carry in their patrol vehicles.

Data Quality Issues

As stated previously, there are several data limitations that need to be mentioned. Because widespread data collection for the CDR program was not implemented until mid-year in 1999, not all unexpected deaths for 1999 were reviewed. Additionally, not every active team submitted completed reviews for 1999 to the state database. The data presented in this report are descriptive due to the small number of reviews. Caution should be used when interpreting data in this report due to the small numbers, especially in the sections describing deaths by specific circumstances. Ideally, the program should have at least two full years of data before attempting more sophisticated analysis of the data. Finally, as the numbers are small and do not represent a complete year of data, caution should be used when interpreting the 1999 CDR data and using it to represent statewide or local death estimates.

Some of the common problems with the data in the state database include missing data (questions checked "unknown" or left unanswered). For example, type of health insurance was unknown or missing in 67% of the deaths reviewed. Some teams may leave a question blank in cases where they think a question is not relevant, rather than marking "not applicable" or leaving questions blank rather than marking "unknown." Another area of concern is the quality of the comments in the committee conclusion sections. Frequently, the comments are very brief and do not clearly spell out the committee's rationale for drawing their conclusion. The narrative section is often left blank, and explaining the value of providing the context of a particular death will be an important part of providing feedback to the teams. By working with local teams and emphasizing the importance of providing additional information and completing all the questions, we will be able to improve these sections.

Table 19: Percentage of data missing or checked unknown by Question, 1999 CDR Reviews

	% Unknown/ Missing
Health Insurance	67.2
Family History of Domestic Violence	61.1
Infant Death section- Birth Certificate Number	26.3
Infant Deaths- Birth weight	57.9
Infant Deaths- Alcohol use in pregnancy	66.7
SIDS-Firmness Bed	53.7
SIDS-Smoking	40.3
Drowning-Had Swimming Lessons	57.4
Drowning-Knew How To Swim	31.6
Suicide-ever attempted in past	61.9
Suicide-History of Mental Health problems	66.7

A more complicated issue is one of sufficiency of data sources. In many reviews, few data sources are included. Some of the teams either do not recognize the need for additional data sources or are limited in their resources to obtain additional data sources. This will require further exploration. On the whole, the teams are well on the way to collecting good quality, consistent data. The teams are very receptive to technical assistance, and the quality of the data continues to improve.

Appendix Two

Local Child Death Review Teams

DOH began funding the development of local teams in 1998. Over the next two years, every county in the state implemented a child death review process. There are now 30 Child Death Review teams, each reviewing deaths of child residents in one or more Washington counties. Team compositions vary from community to community but each has a core membership of Public Health, Child Protective Services, Medical Examiner / Coroner, medical provider, and law enforcement. As you see by the list below (June 2000), all teams also have representatives from a variety of other community services.

Adams County

Co-Coordinator: Karen Potts, Adams County Health District (ACHD)
Co-Coordinator: Karen Walters, ACHD
Gary Brueher, Adams Co Prosecuting Attorney
Kate Brueske, Community Counseling Services
Marty Finan, WA State Patrol
Anne Guerrero, DSHS
Shakti Matta, pediatrician, Columbia Basin Health Associates
Dave McCormick, Chief, Ritzville Police Dept.
Richard Miller, Judge, Adams County Superior Court
Martha Monek, Child Protective Services DSHS
Troy Mock, Adams County Sheriff Dept

Asotin County

Coordinator: Linda Valenzuela, Asotin County Health District
Neal F. Cotner, DCFS
Carmel Donohue, Asotin County Health District
Richard Muszynski, Clarkston Law Enforcement
Ben Nichols, Asotin County Prosecutor
Al Stenoff, DCFS
Jennifer Strange, DCFS
Paulla A. Via, DCFS

Benton-Franklin Counties

Coordinator: Carol Miller, Benton-Franklin Health District (B-FHD)
Dan Blasdel: Franklin County Coroner's Office
Jason Brunson: Benton County Sheriff's Office
Judith Dirks: Catholic Family & Child Services
Jim Harris, Kennewick Police Department
Floyd E. Johnson: Benton County Coroner
Curt King: Pasco Police Department
Steve Lowe: Franklin County Prosecutor

Linda McGlothern: B-FHD
Keri Moe, Division of Child & Family Services
Rick Morrell, West Richland Police Department
Teresa Morrell, West Richland Police Department
Ron Opsal: Lutheran Social Services
Zack Renderer: Kennewick General Hospital
Linda L. Rice, Children's Vista View Clinic
Elaine Ruhlman: B-FHD
Sara Stephens: Educational Institute for Rural Families
Gail Thompson: EDS 123
Kenneth W. Vails, Physicians Immediate Care
A.P. Wehner, Richland Police Department

Bremerton-Kitsap County

Co-Coordinator: Lori Wilkie, Bremerton-Kitsap County Health District (KCHD)
Co-Coordinator: Candace House, KCHD
Data: Hilary Watkins, KCHD
Diane Blake, Suquamish Tribal Office
Tim Drury, Coroner's Office
Doug Dillard, Kitsap County Sheriff
Gary Eddings, Central Kitsap Fire & Rescue
Nell Fairbanks, Kitsap Mental Health
Willa Fisher, Health Officer, KCHD
Donald Johnson, Naval Hospital
Tim Lopez, Bremerton Police Dept.
Laurie Mattson, Port Gamble S'Klallam Tribe
Sandra Morales, KCHD
Bob Palmer, CPS Coordinator Region 5, DSHS
Sue Shultz, Bremerton Police Dept.
Toni Steiner, Harrison Memorial
Tina Stickney, Health District
Lori Thompson, Project Family
Don Ursery, Kitsap County Coroner
Steve Zahl, Dept. of Navy
Sumit Senn, Pediatrician

Chelan-Douglas Counties

Coordinator: Judy Preston, Chelan-Douglas Health District (CDHD)
Data Collection: Beth Hill, CDHD
Mel Coffman, EMS Council
Mike Dingle, Washington State Patrol
Marty Driggs, Administrator, Regional Support Network
Kevin Files, Chelan County Sheriff
Dan LaRoche, Douglas County Sheriff
Linda Michael, Central Washington Hospital
Philip Milnes, Pediatrician, Wenatchee Valley Clinic
Lucy Moro, Social Worker, DSHS
Kevin Overbay, Washington State Patrol
Gina Fino, Chelan County Forensic Pathologist
Doug Shae, Asst Prosecuting Attorney, Chelan County
Robin Wagg, Criminal Investigating Deputy

Clallam County

Coordinator: Chris Borchers, Clallam County Dept of Health and Human Services (CCDHHS)
Ron Allen, Jamestown S'Klalam Tribe
Jonette Bennett, Hoh Tribe
Karen Blore, Olympic Medical Center
Keith Bogues, Port Angeles Fire Department
Captain Skip Gringrich, U. S. Coast Guard Air Station
Joe Hawe, Clallam County Sheriff's Department
Russ Hepfer, Lower Elwha Klallam Tribe
Ben Johnson, Jr., Makah Tribe
John Jones, Quillayute Valley School District
Mike Joyner, Sequim School District
Dave Knies, Washington State Patrol
Gene Laes, Cape Flattery School District
Tom Locke, Health Officer, CCDHHS
Maureen Martin, CPS, DSHS
Charles Mays, Holy Trinity Lutheran Church
Pete Peterson, Clallam County Juvenile Services
Chris Shea, Clallam County Prosecutor's Office
John Wegmann, Peninsula Children's Clinic
Richard Wilson, Crescent School District
George Woodruff, Port Angeles School District
Russell Woodruff, Quileute Tribe
Don Zanon, Peninsula Mental Health

Columbia County

Coordinator: Vickie Hodgson, Columbia County Public Health District
Colleen Fenn: Prosecuting Attorney, Coroner's Office
Mark Franklin: Columbia County Sheriff's Office
Lynna Larsen: Columbia County Public Health District
Lynne Leseman: Columbia County Superior Court
Julia Mead: Dayton Schools
Rocky Miller: Washington State Patrol
Melanie Mings: Columbia County Services
Larry Munden: City of Dayton Fire Department
Aleta Shockley: Dayton General Hospital
Eric Siebel, Dayton General Medical Staff
Barbara Walters: Division of Child & Family Services

Cowlitz County

Coordinator: Beatriz Rush, PHN, Cowlitz County Health Department
See Southwest Washington Child Death Review Coalition Regional Team

Garfield County

Coordinator: Jackie Tetrick, Garfield County Health District (GCHD)
Patty Appel, Nursing Director: GCHD
Clay Barr, EMS: Mayor of Pomeroy
Larry Bowles: Garfield County Sheriff's Department
Dave Boyer: Pomeroy Police Department

Suzanne Grove, Nurse Practitioner: GCHD
John Henry, Prosecuting Attorney
Gail McDonald, Administrator: GCHD
Susan Morrow, GCHD
Suzanne Nelson: EMS
Tima Wymore: Garfield County Hospital Social Services

Grant County

Coordinator: Judy Potter, Grant County Health District (GCHD)
Maryann Beeson, GCHD
Debbie Fenske: Child Protective Services
Peggy Grigg: GCHD
Vicky Kimball, Chief Deputy Register, GCHD
Corbin Moberg, EMS Director: Samaritan Healthcare
Dave Ponozzo: Grant Co. Sheriff's Dept.
RoseMarie Schemper: Samaritan Hosp.
Penny Sibley: County Coroner
Mary Jo Yager: Samaritan Hospital

Grays Harbor County

Coordinator: Karolyn Luzzi PHN, Grays Harbor Public Health & Social Services
Ronald Axtman: Elma Police Department
Michael Bagley: Aberdeen Police Department
Marsha Crane: Mark Reed Hospital ER
Pat Davi: Grays Emergency Medical Services
Ed Fleming: Grays Harbor County Coroner
John Green: Aberdeen Police Department
Mark Herald: Westport Police Department
Angie Humphrey: McCleary Police Department
Steve Hutton: Pediatrician
Becky Kellas: Grays Harbor County Public Health & Social Services (Mental Health)
Gary Loomis: Hoquiam Police Department
Dave McManus: Ocean Shores Police Department
Rick Scott: Grays Harbor County Sheriff's Department
Ray Sowers: Montesano Police Department
Lois Ward: CPS, DSHS
Don Wertanen: Hoquiam Police Department
Jennifer Wielan: Grays Harbor Co. Prosecutor's Office

Island County

Coordinator: Susan Wagner: Island County Health Department
Greg Banks: Island County Prosecutor
Robert Bishop: Island County Coroner
Roger Case: Island County Health Department
Jane Mays: Pediatrician
Cindy McDouga: Children's Protective Service
Catherine Millerp.: Navy Family Services
Linda Morris: Island County HD (Social Services)
Paul Zaveruha: Emergency Services

Jefferson County

Coordinator: Julia Danskin: Jefferson County Health and Human Services
Robin Biffle: Port Townsend Police Dept.
Juelie Dalzell: Jefferson County Prosecutor/Coroner
Jim Decianna: Jefferson General Hospital ER Director
Sherie Dills: Jefferson County Sheriffs Office
Jill Landes, Jefferson County Deputy Prosecutor
Tom Locke, Jefferson County Health Officer
Bill NeSmith: CPS
Stan Thalberg: Jefferson County EMS

Kittitas County

Coordinator: Stephanie McCrone, Kittitas County Health Department
Greg Banister: Kittitas County Sheriff Office
Cheryl Burrows: Kittitas Co EMS Coordinator
Patty Canterberr: Head Start
Neal Cotner: Reg. CPS Coordinator, DSHS
Elise Herman: Ellensburg Pediatrics
Mark Larson: Valley Clinic
Dawn Petre: Comprehensive Mental Health
Greg Zempel: Kittitas County Prosecutor

Klickitat County

Coordinator: Claire Laurelton: Klickitat County Health Dept. (KCHD)
Jim Hagarty, Klickitat County Prosecuting Attorney
Bob Kindler, Klickitat County Sheriff
Lori Koch, Klickitat County Registrar
Carolyn O'Conner: physician
Mary Salter, Supervisor: DSHS
John Thayer, Director, KCHD
Sandra C. Ward, Director: Central Washington Comprehensive Mental Health

Lewis County

Coordinator: Shelly Norman, Lewis County Public Health
See Southwest Washington Child Death Review Coalition Regional Team

Lincoln County

Coordinator: Sheri Bartlett, Lincoln County Public Health Coalition
John Coley: Lincoln County Sheriff
Jim Lippol: Lincoln County Counseling Center
Ron Shepherd: Lincoln County Coroner
Marshall Thompson MD: Lincoln County Health Officer: Child Protective Services
Jim Wiggens: Lincoln County Alcohol/Drug Center

Mason County

Coordinator: Steve Kutz, Director, Mason County Department of Health Services
See Southwest Washington Child Death Review Coalition Regional Team

Northeast Tri Counties (Ferry, Pend Oreille, Stevens)

Coordinator: Julie Bruggenthies, Health Educator: NE Tri County Health District
Fran Lynn: Stevens County Sheriff
Stephen Graham, Ferry County Prosecutor
E.W. Gray, Health Officer, NE Tri Co Health District
Kelly LeCaire, NE Tri County Health District
Tom Metzger, Pend Oreille County Prosecutor
Lee Smutzler, Stevens County Counseling
Edith Vance, DSHS, Stevens County
Jerry Wetle, Stevens County Prosecutor

Okanogan County

Coordinator: Lori Albert, Okanogan County Health District
Vicki Edwards, DCFS
Todd McFarland, Emergency Medical
Bob Nevin, Mental Health
Kreg Sloan, Law Enforcement
Roberta Tuschen, Tribal Representative
Rick Weber, Coroner
Grace Yelland, MD, Pediatrician

Pacific County

Coordinator: Kathy Spoor, Administrator: Pacific County Health Department
See Southwest Washington Child Death Review Coalition Regional Team

Seattle-King County

Coordinator: Karen Brozovich, Public Health – Seattle King County (PHSKC)
Facilitator: Lois Schipper: PHSKC
Byron Byrne, Emergency Medical Services: PHSKC
Kathy Carson, PHSKC
Michael Copass, Harborview Trauma Services & Seattle Medic I Services
Kathy Goater: King County Prosecutor's Office (Child Abuse Prosecution)
Tony Gomez: Injury Prevention: PHSKC
Steve Hama: Safe Futures Youth Center
Richard Harruff: King County Medical Examiner
Robert Jones, MSW: Puget Sound ESD
Paul Mahlum: King Co Sheriff's Office
Carol Mason, Children's Protection Program, Children's Hospital and Med. Center
Jon Nakagawara, King Co Medical Examiner's Office
John Neff, Children's Hospital and Med. Center
Jeff Norman, CPS, DSHS;
Pam Perez, Community Rep, Boys & Girls Club
Amnon Shoenfeld: King Co Mental Health
Naomi Sugar, Pediatrics, Harborview Sexual Assault Center
Elizabeth Thomas, Pediatric Nurse Practitioner
Gwendolyn Townsend: Foster parent and child advocate: One Church, One Child / UJIMA

San Juan County

Coordinator: Nancy Best, San Juan County Health and Community Services (SJCHCS)
Carlene Brevik, Area Supervisor, DCFS
JoAnne Campbell, SJCHCS
Bill Cummings, Sheriff: San Juan County
Randy Gaylord, Prosecuting Attorney: San Juan County
Burk Gossom, Medical Director, EMS: San Juan County
Frank James, Health Officer: San Juan County
Carol LeGate, Deputy Registrar: San Juan County
Jeanne Olmsted, Pediatrician
Edith Thomsen, Public Health Nurse: San Juan County
Barbara Starr, North Island Mental Health
Frank Wilson, Director Emergency Medical Services

Skagit County

Coordinator: Linda Ehrich, Skagit County Department of Health (SCDH)
Bruce Bacon, Skagit County Coroner
Peter Browning, Director: SCHD
Deana Rathkamp, Skagit Co. Children's Mental Health
Paul Johnson, CPS
Howard Leibrand, Skagit County Health Officer & Emergency Services Representative
Patti Turner, Regional CPS Coordinator
Darlene Peters-Edwards, Swinamish Tribe
Les Richards, Pediatrician
Karen Calhoun Wells, Skagit County Prosecutor's Office
Donna White, Pediatrician
Marianne Yamashita, Guardian ad Litem

Snohomish County

Coordinator: Lyn Benak, Snohomish Health District (SHD)
Data Collection: Kathy Kimsey, SHD
Mark Brown, Compass Health
Jay Cook, Snohomish County Police Dept
Jill Dace: Snohomish County CMH
Craig Daly, Snohomish Co. Juvenile Court
Gina Fino: Medical Examiner's Office
Bill France, Child Advocate, Snohomish Co. Prosecutor
Scott Graham: Tulalip Tribes w/Youth Hope House
Anita Hale, Center for Battered Women
Ward Hinds, Health Officer, SHD
Linda Jones, Tulalip Tribes
Patty Turner, CPS Coordinator, Region III DSHS
Anne Mitchell, Community Health, SHD
Ellen Nelson, Emerson Elementary School
Mary Quehn, Counslor, Navy Family Service Center
Bonnie Sandahl, Manager, Providence Health System
Norman Thiersch: Snohomish Co Medical Examiner
Nancy Weis, Dept. of Child & Family Services Oversight Committee
Gail Wellenstein, Pediatrician

Southwest Washington Child Death Review Coalition Regional Team (Cowlitz, Lewis, Mason, Pacific, Wahkiakum Counties)

*Coordinator/Facilitator: Shelly Norman, Lewis County Public Health (LCPH)
*Joell Archibald: Wahkiakum County Health
Glade Austin: Lewis County Sheriff's Office
Sue Baur, Cowlitz Co. Prosecuting Attorney's Office
Brad Bell, Lewis County, Cascade Mental Health
Everett Brown, Washington State Patrol (Lewis Co)
Mike Crowe, Lewis/Cowlitz County, CPS/DSHS
John C. Didion, Washington State Patrol (Pacific Co)
Jim Duscha: Longview Police Department
Kathleen Eussen, LCPH
Laurie Gaston: Providence St Peter Hospital
Jim Gober, Retired Court Commissioner: Lewis County
Cindy Hambley: Thurston County Medic One
Edith Hitchings, CPS Coordinator, Region 6 DSHS
Bill Hurley, Emergency Medicine, Providence St. Peter Hospital
Fred Johnson, Wahkiakum County Prosecutor
Tim Kittelson, CPS , Cowlitz County, DCFS
*Steve Kutz: Mason County Department of Health & Human Services
Sandy Loren, School Nurse: Cowlitz County
Olga Lozano, Longview Police Department
Debbie Lynn, CPS, Pacific County, DSHS
Kenn Mackintosh, Mason County Sheriff's Dept
Dana Magee, Lewis County, Addictions Recovery Center
Judy Marsyla, Wahkiakum County HD
Les Monroe, Cowlitz Co. HD
Pride Mutoli, Mason County Council on Abuse and Neglect
Mike Nichols: Cowlitz County Coroner
Dick Nuse: Traffic Safety Commission
Rocky Pfitzer: Shelton Police Department
Barb Pitharoulis, CPS, Mason County, DSHS
Martha Reed: Mason County Coroner
Ron Renbarger, Environmental Health, Lewis Co. HD
*Beatriz Rush, Cowlitz County HD
Madelyn Schwartz: Youth Suicide Prevention Committee
Becky Smith, CPS/CWS: Lewis County, DCFS
*Kathy Spoor, Administrator: Pacific County HD
Ginny Tausche: Mason County HD
Blaine Tolby: Cowlitz Co., Pediatrician
Mark Trucksess, Public Health Officer, Mason Co.
Terry Wilson: Lewis County Coroner
Kim Zillyett, Pacific County, Shoalwater Bay Indian Tribe

* = Local Health Jurisdiction Child Death Review Coord

Southwest Washington (Clark & Skamania Counties)

Coordinator: Karen Steingart, Health Officer: Southwest Washington Health District (SWWHD)
Data Collection: Maya Bhat, SWWHD
Karen Batroukh, Nurse: Vancouver School District
Terry Cockrum: Fire District #6

Art Curtis, Prosecuting Attorney: Clark County
Marian Gilmore, Child Protective Services, DSHS
Kevin Harper: Clark County Sheriff's Office
Susan Jacobs, School Nurse: Vancouver School District
Marc Muhr: Clark County Emergency Medical Services
Steve Norton: Vancouver Police Department
Janet MacDonell, Pediatrician: Kaiser Permanente
Mary Renaud: SWWHD
John Stirling, Pediatrics: Vancouver Clinic
Ray W. Hinea III: Attorney General's Office
Jo Waddell, CASA Director: YWCA
Dennis Wickham, MD, Medical Examiner: Clark County
Jane Scott, Vancouver Police Department
Erin Noland, Clark County Sheriff's Office
Rick Buckner, Clark County Sheriff's Office
Anna Meddaugh, SWWHD

Spokane County

Coordinator: Paul Stepak, : Spokane Regional Health District
David Crump: Spokane Mental Health
Barbara Feyh: Spokane Regional Health District
Cathy Fritz, Spokane Regional Health District
Jerry Frye, Spokane Police Department
James Goodwin, Spokane County Sheriff's Dept
Deborah Icenogle: Spokane Pediatrician
Mark Lamininger, Deputy Prosecuting Attorney
George Lindholm: Spokane County Medical Examiner
Mary Ann Murphy: Casey Family Partners
Connie Mutton: Sacred Heart Medical Center
Carol Pilcher: Deaconess Medical Center NICU
Jeff Rittenhouse: American Medical Response
Deb Schaeffer: Deaconess Medical Center NICU
Rob Schebor: DSHS Children's Administration
Randy Shaber, Chief Deputy Investigator: Spokane County Medical Examiner's Office
Lori Taylor: Sacred Heart Medical Center
Kim Thorburn, MPH & Health Officer, SRHD

Tacoma-Pierce County

Coordinator: Medori Hill, Comm. Health Assessor, Tacoma-Pierce County Health Department (TPCHD)
Co-Coordinator: Riley Peters, Epidemiologist, TPCHD
John Howard, Medical Examiner
Roberto Ramoso, Associate Medical Examiner
Brent Bomkamp, Pierce County Sheriff
Jim Callaway, Tacoma Police Department
James Noel, physician: Madigan Army Medical Center
David Estroff, physician: Madigan Army Medical Center
Robert Palmer, Child Protective Services, DSHS
Mady Murrey, Mary Bridge Children's Hospital
Louise LaForest, Trauma Coord, Multicare Health Sys.
Cliff O'Callahan, physician: Puyallup Tribal Health

Robert Beilke, Pediatric Psychiatric Services
Ralph Johns, Tacoma Fire Chief, EMS
Sue Walen, TPCHD

Thurston County

Coordinator: Diana Yu, Health Officer, Thurston County Health Department (TCHD)
Data Collection: Ruby Dorn, Registrar, TCHD
Judy Arnold: Thurston County Coroner
Jim Costa: Olympia Police Department
Edith Hitchings, CPS Coordinator, Region 6, DSHS
Bill Hurley, Emergency Physician, Providence St Peter Hospital
Joe Pellicer: Medical Director, Thurston Co. Medic One
Mary Snow: Thurston County Safe Kids Coalition
Frank Spickelmire, Olympia Fire Department

Wahkiakum County

Coordinator: Joell Archibald, Administrator Wahkiakum Co Health Dept.
See Southwest Washington Child Death Review Coalition Regional Team

Walla Walla County

Coordinator: Vikki Davis, Walla Walla County-City Health Department
Ann Ames, Walla Walla County Coroner's Office
Marcie Anderson, Teacher
Ron Ayers, Walla Walla City Fire Department
LouAnne Cummings, Physician
Mike Humphrey, Walla Walla County Sheriff's Office
Calvin Hussey, Child Protective Services, DSHS
Nina Konn, Emergency Services Walla Walla County
Carol Rupe, Nurse Practitioner
Laurie Wolfrom, School Nurse

Whatcom County

Coordinator: Sylvia Fragner, Whatcom County Health and Human Services Dept (WCHHSD)
Data Collection: Margarette Ortiz, WCHHSD
Gary Goldfogel, Medical Examiner
Terri Graham: Lummi Law & Order
Glenn Hutchings: Bellingham Police Dept.
Nancy Bischoff, Pediatrician
Charles Snyder, Superior Court Commissioner
Greg Stern, Health Officer
Patty Turner, CPS Coordinator, Region III DSHS
Jacob Vohs, CPS

Whitman County

Coordinator: Fran Martin, Administrator, Whitman County Health Department (WCHD)
Don Anderson, Undersheriff, Whitman County Sheriff
Polly Anderson, Vital Records Registar, WCHD
Fred Baker, Pullman Police Department
Mary Lou Bennington, Mental Health
Chad Connors, Juvenile Court

Al Frostad, Pediatrican
Jim Kaufman, Whitman County Pros Attorney
Pete Martin, Whitman County Coroner
Greg Miller, Washington State Patrol
Tim Moody, Health Officer, WCHD
Barbara Sheffler, DCFS

Yakima County

Coordinator: Diane Patterson, MCH Director Yakima Valley Memorial Hospital
Data: Eileen Hunt, Registrar, Yakima Health District
Kerrie Cavaness: Safe Kids Yakima County
Neal F. Cotner: CPS Coordinator, Region 2, DSHS
Paul DeBueschere, physician, Yakima Neighborhood Health Clinic
Danny English: Yakima Indian Nation Public Health
Margie Fontana, Maternity Case Manager
Faye Fuchs: ESD 105
Shawnie Haas, Director: Yakima Valley Memorial Hospital ER
Chuck Heath: Yakima Fire Department
Karri Livingston: DCFS OCCP
Brenda Matthewsr: Yakima Valley Farmworker's Clinic
Gerri Miller, Public Health Nurse: Yakima Health Dist.
Patti Powers: Yakima County Prosecutor's Office
Maurice Rice: Yakima County Coroner
Carlos Saldivar: DCFS Supervisor
Nicole Southard: Comprehensive Mental Health
Don Stangle, Director: Yakima County EMS
Christy Waters: Yakima County Coroner's Office

Appendix Three

Local Health Jurisdictions Child Death Review Team Activities 1999

1. Adams: Identified potential team members; sent out letters explaining Child Death Review; planned first team meeting to be held January 2000.

2. Asotin: Identified team members; planned first team meeting to be held in April 2000.

3. Benton-Franklin: The CDR team was convened in 1994 as a DSHS CPS fatality review body. In 1998, it broadened its focus to include all unexpected deaths of children. The team meets quarterly.

4. Bremerton-Kitsap: The CDR team was convened in early 1999. The team met monthly, completing two reviews per meeting; adopted a CDR Confidentiality Agreement and an Interagency Agreement; supported a SIDS training to include team members; review identified need for collaboration between PHN's and fire educators about availability and use of home smoke alarms.

5. Chelan-Douglas: The CDR team was convened in mid 1999. The one unexpected 1999 child death was to be reviewed by the CDR team in February 2000. The team met monthly to consider injury prevention issues. For example, they created a business card giving suicide risks and how to help tips.

6. Clallam: The CDR team was convened in 2000.

7. Columbia: There were no unexpected child deaths in 1999. The CDR team was convened in October 1999 and agreed to meet quarterly for consideration of community injury prevention concerns and be available should a review be needed.

8. Cowlitz: Cowlitz is a member of a five county regional consortium for child death review. Several Cowlitz County professionals were recruited for the regional CDR team which began meeting in April 1999.

Local members meet prior to each regional meeting to gather records. Six unexpected 1999 Cowlitz child deaths were reviewed.

9. Garfield: The CDR team was convened in September 1999 and agreed to meet quarterly with a focus on continuing & expanding existing child injury prevention activities. There were no unexpected child deaths in 1999. This team will be available should a review be needed.

10. Grant: The CDR team was convened in September 1999 and meets quarterly. Two 1999 unexpected child deaths were reviewed.

11. Grays Harbor: The CDR team was convened in July 1999 and meets quarterly. Two unexpected 1999 child deaths were reviewed.

12. Island: The CDR team was formed in 1997 and meets as needed to review unexpected deaths of children. In 1999, the team reviewed 4 deaths from 1998.

13. Jefferson: The Violence Intervention Prevention Support Team (VIPST) serves as the CDR team with additional members invited as indicated by the circumstances of the death to be reviewed. There were no unexpected child deaths in 1999.

14. Kittitas: The CDR team was convened in June 1999 and met again in November to learn about the CDR process by reviewing three pre-1999 child deaths. There were no unexpected child deaths in 1999.

15. Klickitat: The CDR team was convened in December 1999 and reviewed the one 1999 unexpected child death at that meeting.

16. Lewis: Lewis is a member of a five county regional consortium for child death review. Several Lewis County professionals were recruited for the regional CDR team that began meeting in April 1999. Seven unexpected Lewis County child deaths were reviewed and four were deferred until 2000 because of active criminal investigations.

17. Lincoln: The CDR team was convened in 2000. There were no unexpected child deaths in 1999.

18. Mason: Mason is a member of a five county regional consortium for child death review. Several Mason County professionals were recruited for the regional CDR team that began meeting in April 1999. Six unexpected Mason County child deaths were reviewed and one was deferred until February 2000.

19. Northeast Tri-County (Stevens, Ferry, Pend Oreille): The CDR team was convened in 2000

20. Okanogan: The CDR team was convened in December 1999 and meets quarterly. There were no unexpected child deaths in 1999.

21. Pacific: Pacific is a member of a five county regional consortium for child death review. Three Pacific County professionals were recruited for the regional CDR team that began meeting in April 1999. One 1999 unexpected Pacific County child death was reviewed. An injury prevention issue (use of pea gravel in play areas of young children) identified at the regional team was addressed with childcare providers in Pacific County.

22. Public Health – Seattle & King County: The CDR team was convened in 1998 and meets monthly. Sixty-seven (67) child deaths were reviewed in 1999 of which fifty-one (51) were deemed preventable. Numerous risk reduction issues were identified and local intervention actions taken, including a letter supporting a code revision to prohibit swimming in one area with heavy boat traffic and a reminder letter about importance of infant sleep safety education sent to 14 birth hospitals in King County.

23. San Juan: The CDR team was convened in early 1999 and meets quarterly. Members reviewed 16 child deaths occurring from 1988-1998 in order to better understand the child death review process. There were no unexpected child deaths in 1999.

24. Skagit: The CDR team was convened in early 1999 and meets quarterly. Five 1999 unexpected child deaths were reviewed and the following prevention issues were addressed: Discussion about the complexities of legal intervention with drug-affected pregnant women; Recommendation to the State Senate Transportation Committee to strengthen the teen driver legislative proposal; Increased public education about SIDS risk factors.

25. Snohomish: The CDR team was convened in 1998 and meets quarterly. Thirty-one (31) 1999 unexpected child deaths were reviewed and several risk factors were identified for each cause of death. In addition, the team formed a subcommittee to review selected neonatal deaths (not included in the DOH child death review system) for issues related to preventability.

26. Southwest Washington (Clark & Skamania Counties): The CDR team was convened in 1994 and meets quarterly. Seven unexpected 1999 child deaths were reviewed. Prevention issues identified by the team included: infant sleep position; parental drug & alcohol abuse; drowning; firearm safety.

27. Spokane: The CDR team was convened in 1991 and meets monthly. In 1999, approximately 35 unexpected child deaths were reviewed.

Spokane has prepared several reports to the community since the team's inception. Each provides an aggregate picture of the cause and manner of child deaths and makes recommendations for community prevention.

28. Tacoma-Pierce: The CDR team was convened in early 1999 and meets monthly. Thirty-five (35) deaths were reviewed in 1999, twenty-six (26) of which were deemed preventable. In addition, the team formed a medical sub-committee that screens medical/natural deaths (excluded in the DOH child death review system) for potentially preventable causes.

29. Thurston: The CDR team was convened in Spring 2000.

30. Wahkiakum: Wahkiakum is a member of a five county regional consortium for child death review that began meeting in April 1999. Three local professionals are members of the regional team. There were no unexpected deaths of children from Wahkiakum County in 1999.

31. Walla Walla: In 1999, the CDR team consisted of 2 members who reviewed five deaths. In 2000, the team is being expanded to include representation from more community agencies.

32. Whatcom: The CDR team was convened in 1998 and meets quarterly. The team reviewed seven unexpected 1998 child deaths and four unexpected 1999 child deaths. In addition, the regional assessment coordinator compiled summary statistics for twenty-one child deaths occurring during 1997 &1998 and reviewed by the CDR team in 1998 and 1999. Numerous prevention policy issues were identified.

33. Whitman: The CDR team was convened in Spring 1999 and meets quarterly. Four 1999 unexpected child deaths were reviewed.

34. Yakima: The CDR team was convened in Fall 1998 and meets monthly. By team decision, 36 child deaths were reviewed in 1999, including 18 "expected" deaths that are not included in the DOH CDR system. A list of prevention recommendations was compiled and will be disseminated to community during 2000.

Prepared by Melissa Allen from 1999 LHJ Year-End Reports